Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The 0208.90.R3 Waiver renewal application is for a five year period, from 7/1/08 through 6/30/13. Significant changes in this renewal application include the following:

1. A request to increase the projected number of unduplicated persons to be served from 2,200 to 2,300 for renewal years one through five.

2. A request to delete the negotiated respite service option, and waiver language relating to this option (e.g., respite language has been deleted from the W-5 Freedom of Choice form). Negotiated respite refers to respite provided by a worker who is not an employee of an agency with a DDP contract. Effective 7/1/08, all respite will be provided by employees of agencies with a DDP contract.

3. A request to update the rates for services in Appendix J, based on the Department's FY 08 rates schedule. The Department's new rates schedule will go into effect on a statewide basis 7/1/08 (FY 09). Projected increases in the future cost of services are based on an inflation factor of 3%/year. To clarify, the FY 08 rate schedule was increased by 3% for FY 09 (year one of the renewal period) and by 3% for every year of the renewal period thereafter.

IN SUMMARY

For the purpose of this renewal application, the Department is using the Quality Assurance Strategy approved by CMS on 4/29/08 for the 0208.90.R2.03 Waiver amendment request. This language may be reviewed in 8.B. of the Main Section of this renewal application. The Department will modify the annual QA Review process for children's and adult services as indicated in various performance measures of the quality improvement sections of appendices A,B,C,D and G, effective 7/1/08.

The Department will request CMS approval for a waiver amendment, effective 7/1/2010, for the purpose of achieving compliance with all aspects of the V3.5 Quality Improvement Strategy. The waiver amendment request will be submitted on or before 3/31/10.

The State assures CMS that this waiver renewal request will be fully compliant with all applicable regulations related to case management by no later than 3/3/10. Any amendments required to achieve full compliance will be submitted to CMS at least 90 days in advance of this date.

In addition to the above, waiver language has been updated, where needed, to ensure that obsolete language has been either deleted or modified.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Montana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Home and Community-Based Waiver for Individuals with Developmental Disabilities

C. **Type of Request: renewal**

Original Base Waiver Number: MT.0208
Waiver Number: MT.0208.R02.00
Draft ID: MT.04.02.00

D. **Type of Waiver** (*select only one*):
Regular Waiver

E. **Proposed Effective Date:** (*mm/dd/yy*)

07/01/08

Approved Effective Date: 07/01/08

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of this waiver is to provide the necessary support options to help Montanans with developmental disability achieve and maintain a good quality of life. This goal hasn't changed since the fall of 1981 when this waiver was initially approved. Residential supports for persons in natural homes, group homes, foster homes and apartments account for more than half the annual waiver expenditures. Other highly utilized services include congregate work/day, supported employment, transportation, an expanded form of children's case management and respite.

This waiver currently serves about 2,000 Montanans with developmental disabilities (DD) of all ages. The agency responsible for administering the waiver is the Developmental Disabilities Program (DDP) of the Department of Public Health and Human Services. The DDP maintains ten field offices in five regions, and a central office in Helena. DDP field staff are responsible for establishing eligibility for services, completing annual Level of Care (LOC) activities, conducting screenings for service openings, processing invoices, contracting, attending planning meetings as needed and generally ensuring service provider compliance with the rules, policies and laws governing DDP waiver funded services.

Services are delivered by more than 56 contracted providers to persons in a variety of settings. Case management is funded under the waiver for children with intensive service needs and their families. All adults 22 years of age and older receive State Plan Targeted Case Management (TCM). Slightly more than half of the adult services case managers are DDP employees. The rest are employees of corporations contracting with the DDP for the provision of case management services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (•) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are

met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited

in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The DDP is responsible for chairing numerous workgroups involved in many aspects of the service delivery system. The purpose of these workgroups is to gain input from stakeholders prior to making changes in the DD

service system. Workgroups are typically comprised of members involved in all facets of the DD service system. Copies of the various workgroups membership lists and meeting minutes (e.g., pertaining to quality assurance, incident management, case management, sex offender treatment, child and family services, personal supports planning (PSP), rates setting advisory committee, Agency Wide Accounting and Client System (AWACS) rewrite, training systems for direct care staff, et. al.) are available upon request.

The Strategic Planning Across Montana (SPAM) workgroup is used to gather input for the purpose of enhancing the DD service system. This workgroup was very active during calendar year 2007 in developing a working document serving to map the future of DD services. Public participation in this process was encouraged by public awareness campaigns, including statewide public service announcements in local newspapers and television. A copy of the SPAM outcomes and system change implementation schedule is available upon request.

DDP management staff remain open to consumers, families, provider and State staff input and ideas for improving services. An e-file is maintained by the waiver specialist and these ideas are reviewed by DDP management prior to waiver renewal and waiver amendment requests.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Jones

First Name: Perry

Title: Developmental Disabilities Program DD Waiver Specialist

Agency: Department of Public Health and Human Services

Address: PO Box 4210

Address 2: 111 Sanders

City: Helena

State: Montana

Zip: 59604

Phone: (406) 444-5662 **Ext:** **TTY**

Fax: (406) 444-0230

E-mail: pjones@mt.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:	
Address:	
Address 2:	
City:	
State:	**Montana**
Zip:	
Phone:	**Ext:** **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Duane Preshinger
	State Medicaid Director or Designee
Submission Date:	Jun 2, 2008

Last Name:	Preshinger
First Name:	Duane
Title:	Senior Medicaid Policy Manager
Agency:	Montana Department of Health and Human Services
Address:	PO Box 4210
Address 2:	111 Sanders
City:	Helena
State:	**Montana**
Zip:	59604
Phone:	(406) 444-4145
Fax:	(406) 444-1970
E-mail:	dpreshinger@mt.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The following text is Quality Assurance Process from Appendix H as approved on 4/29/08 for the 0208.90.R2.03 Waiver. The text has been updated, is current as of 5/23/08, and, in combination with new performance standards in various appendices of this renewal request, serves as the template for the quality assurance efforts of the Department effective 7/1/08. The Department will request CMS approval for a waiver amendment, effective 7/1/10, to be in full compliance with all aspects of the of the Version 3.5 Quality Improvement Strategy requirements. Updated text follows.

The DDP has developed and implemented codes, rules and policies designed to ensure compliance with the six assurances required for waiver approval. Significant efforts have been made over the last few years to update and improve various aspects of the DD service system, e.g. the billing and payment system, the client planning process, rates and client resource allocation methodologies, incident management, et. al. In addition, much effort has been focused on ensuring provider compliance with all these changes, and the development of monitoring protocols designed to ensure that providers are keeping up with the requirements.

In reviewing the standards associated with this section, it is apparent that additional work is needed in two areas:

1. Systems need to be in place to enable the DDP to evaluate the system as a whole in the ongoing analysis of system performance (trend analysis).

2. Systems are needed to effectively evaluate the performance of DDP staff in fulfilling required Department functions and obligations.

Development of solutions for current deficiencies in these areas will be ongoing; DDP's initial efforts follow in this Appendix.

Level of Care Determinations

No adult may be placed on the waiting list or enter waiver services without the review of the documentation supporting a diagnosis of developmental disability by the designated DDP QIS or the Regional Manager. Documentation of developmental disability is maintained by the QIS and also forwarded to the DDP central office to facilitate fiscal and programmatic auditing.

Child and Family service providers are responsible for initially determining if a child referred for IFES meets the State definition for developmental disability under MCA 53-20-202, and if the child has significant deficits in self-help skills (adaptive behaviors), serious medical challenges and/or significant behavior problems. The diagnostic information used to support the child's eligibility determination and need for intensive level services is referenced or included in the referral. Children may be screened only after a referral has been generated, subject to the requirements outlined in the Policy and Procedures for Intensive Family Education & Support Services. Similar standards for referral information are outlined in the DD Case Manager's Handbook for persons seeking adult services. The LOC process conducted by the DDP QIS serves to verify the initial and ongoing presence of developmental disability, and the initial and ongoing need for specific ongoing waiver supports based on behavioral issues, self-help skill deficits and medical issues.

Documents used for completing initial and ongoing LOC activities are referenced in Appendix B.

Oversight- The DDP does not systematically review the initial and annual LOC documents maintained in the DDP QIS regional and satellite offices. Establishing a DDP internal monitoring process to ensure ongoing compliance with CFR 441.302 (outlined on pages 226 and 227 of the CMS Instructions, Technical Guide and Review Criteria dated 11/05) is needed at this time.

Functionally, this breaks into the following identified needs:

1. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) establishment of eligibility for DD services. The person is placed on a waiting list. After a person is selected for services, the DDP QIS and Foundation Nurse completes the required LOC activities.

Effective 7/1/08, the DDP will implement a sampling process to ensure that eligibility determinations are made in a timely manner. This sampling process applies to determinations made for children by C&F intake workers and determinations made by DDP QIS staff for persons referred for adult services. Eligibility determination span is defined as the elapsed time between the date a person initially requests a determination, and the date of the eligibility outcome letter generated for the recipient. This sampling process will be incorporated into the DDP CMS QA process for both adult services and children's services. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

2. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) placement of a person on the waiting list (WL), as verified in the AWACs database.

Effective 7/17/08, the DDP will implement a sampling process to ensure that persons are placed on the WL in a timely manner. This sampling process applies to WL placement for children and adults in AWACS by the DDP Regional Administrative Assistant. The time span is defined as the elapsed time between the date the provider (for children's services) or case manager (for adult services) submits a written request for placement on the WL, and AWACS date. This sampling process will be incorporated into the DDP CMS QA process for both adult services and children's services. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

3. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) completion of LOC forms for DD waiver services.

Effective 7/1/07, the DDP implemented a sampling process to ensure that LOC documents are completed in a timely manner. This sampling process applies to LOC initial evaluations made for children and adults made by DDP QIS staff for persons newly entering the waiver. Timely is defined as completion of the Waiver 1 and Waiver 3 forms within 30 days of the waiver enrollment date listed in the MMIS for sampled recipients. Data is compiled on a quarterly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

4. Assignment of DDP personnel or person designated as responsible for conducting these functions.

Effective 7/1/08, the DDP Waiver Specialist will be responsible for updating the CMS QA file with annual information in the monitoring of these functions.

5. Development of anchors to enable consistent evaluation of the quality of the eligibility determinations and initial LOC process outcomes. This would include a confirmation that the required forms were used, and documented outcomes were based on approved assessments. A sampling process is needed.

Effective 7/1/08, the Eligibility Determination Form guidelines developed for use by child and family service provider intake staff, and used by DDP QIS staff will either be reviewed (in the case of adult determinations) or applied to the eligibility outcomes for children on a sample basis by the Waiver Specialist. A determination of "DD" under the Montana State definition is the most critical piece of information in the initial LOC process. After the initial LOC is completed, the LOC re-evaluation is designed to ensure that treatment needs continue to mesh with the services being delivered. The DDP Waiver Specialist will be responsible for updating the CMS QA file with annual information in the monitoring eligibility determination outcomes. Specifically, the cognitive assessment and adaptive behavior assessment results for sampled individuals will be compared with the requirements outlined in the CDMW guidelines.

6. Development of an annualized sampling process to establish DDP staff compliance (as indicated above) in completing timely re-evaluations of LOC.

Effective 7/1/07, the DDP implemented a sampling process to ensure that LOC re-determination documents are completed in a timely manner. This sampling process applies to LOC documents completed for children and adults by DDP QIS staff. Timely is defined as completion of the Waiver 1 (if requested by the QIS) and Waiver 3 forms within 365 days of the previous LOC evaluation, based on the dates on the W-3 forms. Data is compiled on a quarterly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

7. LOC decisions have potential to adversely impact a recipient or family as it relates to the determination of eligibility. In cases when a person is found not DD eligible, eligibility may be contested and the fair hearing process invoked. But it is

also possible that persons who aren't DD in accordance with processes used to interpret the State definition could be found eligible for DD services. The State needs to consider implementing a process to review DD eligibility determination outcomes for the purpose of continuous quality improvement in updating and improving the process and the instruments used to verify eligibility. This activity is complicated by the fact that tools, indicators and assessments used for establishing DD eligibility for young children are different than those used for adults.

The outcomes of eligibility determinations for persons found "not DD" will be annually sampled by the Waiver Specialist and the data results will be compiled for the purpose of supplementing the information included in the eligibility outcome data maintained under #5, above. This activity will be implemented effective 7/1/07. Decisions made to change any aspect of the LOC or eligibility determination process will be data based.

Service Plans-

Service plans for children and adults must (minimally) address the standards outlined in rule. Plan requirements may be reviewed in ARM 37.34.1401 through 37.34.1407. Plans are based on assessed needs and the expressed desires of the individual and/or family.

Service plans address assessed needs and goals, and implemented in accordance with requirements

In children's services:
C&F assigned provider staff contact the families and verify satisfaction with the plan and the services being delivered. FSS plans of care are reviewed on a sample basis by the assigned C&F provider staff. The DDP QIS reviews and approves 100% of the annual plans of care for IFES recipients. Problems with plans are noted in the QA review process. Identified problems are addressed at level of the FSS and the reviewing authority. Satisfaction surveys are also completed by the family and returned to the agency. Problems are identified and follow up occurs at this level, if needed. The QIS reviews a sample of IFSP documents as part of the annual QA review to determine if objectives from previous planning meetings were properly addressed and rules governing the plans of care have been followed, including the requirement for the timely implementation of the plan. Finally, the QIS meets with a sample of families served to ascertain overall levels of satisfaction with services.

In adult services:
Adult TCM supervisors review samples of plans of care for adult recipients, including reviewing the plans against required standards for content, and timely implementation.
External consumer satisfaction surveys are completed annually for every adult waiver recipient by the adult TCM prior to planning meetings. Agency satisfaction surveys are also completed by the recipient, family and/or interested other and returned to the agency. Problems are identified and needed follow up occurs at this level. Finally, the DDP QIS reviews a sample of plans to ensure that achieved outcomes are satisfactory, and that plans comply with the rule and policy requirements.

Adults, children and families who are not satisfied with their plans of care have several avenues for redress (outlined elsewhere in this document), up to and including requesting a new service provider or case manager, or requesting a fair hearing in the event of the denial of a requested Medicaid reimbursable service. DDP relies on consumer satisfaction data and the review of a sample of plans and family interviews to capture this information annually and to summarize information by provider in the QA report. Results of the review efforts of the DDP QIS and provider systems of internal review are currently focused on solving problems related to the plans at the individual and provider level.

Systems for monitoring plan progress, team/plan responsiveness to changing needs, and the performance of providers and case management in plan follow through:

In children's services, six month review meetings are held by the team to review plan progress and to review the need to adapt the plan based on the changing needs of the family or child. Meetings may be held on a more frequent basis, as requested by the family.

Failure by the provider to provide the services as specified could be resolved in a number of ways, including the option of using the on call number to the assigned agency staff and/or calling the assigned Family Support Specialist. Changing needs may require additional service dollars to bolster the plan of care, in situations when the provider is providing the contracted hours of support, but more support is needed. Requests for additional waiver support dollars require the planning team to agree on the quantity and type of supports and the projected length of time the additional supports will be needed. The case manager would initiate this process. In this case, the service provider would request additional funding from the DDP in the form of a crisis or discretionary grant. In general, the case manager is responsible for follow up, to

ensure that services are being delivered and the family is satisfied with the services.

In adult services, quarterly summary reports generated by providers are sent to the Adult TCM to enable data based decisions to be made regarding plan progress. The case manager is responsible for follow up, if needed. Typically, recipients in individualized residential settings would access supports from providers using the on-call system before notifying their case manager. Lack of progress, failure on the part of the provider to deliver the supports specified in the plan, or dissatisfaction with the plan are some of the reasons a special planning meeting would be called by the case manager. Special or emergency planning meetings may be called by the service provider, the recipient, a family member or legal guardian, the case manager, the QIS, or any other person acting on behalf of the recipient. The case manager is responsible for the coordination and scheduling of these meetings.

Failure of the team or the provider to adequately address service delivery issues at the planning team level may result in several possible outcomes:
- The internal agency grievance process is used. The problem may be resolved at the provider level.
- The IP team appeal process is used. Issues are referred to a review board comprised of a case manager, provider representative, parent and a service recipient. The decision is documented in a letter from the DDP Program Director.
- The Department fair hearing process is invoked, if the problem is related to issues outlined in the ARM and MCA (specific references available in Appendix F). The culmination of this process is a decision made by the Department Fair Hearings Officer.
- Significantly, part of the annual planning process is devoted to reviewing the status of objectives set at the previous meeting(s). Dissatisfaction with the delivery of services expressed in the planning document could result (depending upon the issue) in the information being shared with the QIS for follow up. Lack of provider compliance could result in the initiation of the corrective action process.

In children's services, failure of the team to adequately address issues at the planning team level may result in several possible outcomes:
- The internal agency grievance process is used. The problem may be resolved at the provider level.
- The planning team appeal process is used. The issue is referred to the IFES Appeal Committee comprised of the Child and Family Service Coordinator, Waiver Specialist and a DDP Bureau Chief. The outcome of this process is a documented in a letter from the DDP Program Director.
- The Department fair hearing process is invoked, if the problem is related to issues outlined in the ARM and MCA (specific references available in Appendix F). The culmination of this process is a decision made by the Department Fair Hearings Officer.
- Significantly, part of the annual planning process is devoted to reviewing the status of objectives set at the previous meeting(s). Dissatisfaction with the delivery of services expressed in the planning document could result (depending upon the issue) in the information being shared with the QIS for follow up. Lack of provider compliance could result in the initiation of the corrective action process.

At this time, there is no external process serving to review total system performance in ensuring compliance in the delivery of supports based on the planning process used in children's or adult services. There is no statewide summary data (other than provider-generated paid claims histories which may reflect only limited service information) serving to track system trends in the delivery of services and supports in accordance with the plans of care. Customer satisfaction data is used to solve individual problems, and the provider aggregates customer satisfaction data from the provider surveys, but this information is not used by the DDP to track system trends at this time. Service delivery problems continue to be identified and resolved at the individual client level, or at the individual provider level. Data results of the planning process at the provider level may be reviewed for the Annual Quality Assurance Reports completed by the DDP QIS.

The salient issues of the planning process for children's and adult services include:

1. Did the meeting occur within 4 weeks of entry into services?
2. Did annual meetings occur at intervals not exceeding 365 days?
3. Were objectives implemented within the timeframes specified in the plan?
4. In reviewing the objectives set at the previous meeting, did the provider and case manager complete assigned objectives?
5. In the event that rights restrictions or level 1 or level 2 aversive procedures were approved, were the procedures outlined in the Administrative Rules of Montana (ARM) governing these procedures followed?
6. Are consumers, advocates and family members satisfied with the planning outcomes?

Annual plan of care outcome data based on #1-5, above, will be compiled by the case manager supervisors for a sample of recipients. Data summaries will be forwarded to the Waiver Specialist. This data will be maintained in the CMS assurances file, and will be summarized annually by the Waiver Specialist. This requirement will become effective 7/1/07.

The DDP has modified the annual planning process for adults to incorporate personal supports planning features. It is unclear at this time if and when the planning process used with children in IFES will be modified for the purpose of incorporating the personal supports planning features of the adult planning process. Efforts to incorporate the automated reporting of the annual planning process will follow the implementation and finalization of a planning tool on a system wide basis for adults and children. There is no date set for automating the planning process at this time.

Participant Choice of Waiver Services and Institutional Care, and Choice Between/Among Waiver Services and Providers-

Adult Services and Children's Services

The Waiver-5 Freedom of Choice form is specific to the aforementioned choices and is completed for every recipient, annually. It is the responsibility of the assigned case manager (FSS or adult TCM) to complete this document on an ongoing basis with the recipients, legal guardian, or a person who acts on behalf of the recipient. This form and accompanying Explanation of ICF-MR Services and Fair Hearing Rights document, ensure consistency in the sharing of this critical information related to choice between waiver services and institutional care, choice of waiver services available to the participant, and choice of provider for these services.

The choice of institutional care is somewhat limited in Montana, since placement in the ICF-MR requires a court order. This is explained in the explanation of services form, designed to accompany the W-5 form.

The external process serving to review system performance in ensuring compliance in the scheduling and completion of the Waiver 5 form, and DDP QIS staff performance in ensuring the DDP client waiver files are updated annually with new Waiver 5 forms was implemented effective 7/1/07. The DDP QIS is responsible for ensuring this form is completed annually, and the QIS is responsible for the maintenance of the forms in the client waiver files.

The DDP Waiver Specialist will monitor the annual completion of the W-5 form on a sample basis.

Qualified Provider Standards
This section addresses the DDP's need to ensure providers are initially qualified to provide services, and providers maintain these standards in the ongoing provision of services. This includes reviewing the licensure and certification status of required residential facilities (e.g., group homes, foster homes, assisted living facilities) and professional licensure/certification standards for medical and therapy services (e.g., PT, OT, Speech Therapy, Nurse, Dietician, etc). In addition, unlicensed and non-certified direct service providers (persons providing transportation rides, residential habilitation, respite, supported employment, etc.) are reviewed. For persons providing unlicensed or non-certified services, training requirements are key assurances that an employee or contractor is qualified to perform the work.

Children's Services
The Child and Family Qualified Provider Handbook: A Guide for Qualification as a Provider to Developmental Disabilities Services to Children With or at Risk of Developmental Disabilities document outlines the various requirements necessary for a provider to achieve qualified provider status for delivering Intensive Family Education and Support.

Specific to foster home licensure: The qualified provider handbook checklist item #69 states that the provider must have policies, procedures and practices in place to assure that all children's foster homes receiving waiver-funded supports are licensed in accordance with relevant rules, and that copies of the licenses are available upon request. This requirement is reviewed annually under checklist #67, children's waiver services foster homes are licensed in accordance with relevant rules, and copies of the licenses were made available for review. This information is sampled; not every foster home license would be reviewed as part of the QA Review. Licensure information is not summarized by the DDP on a statewide basis for trend analysis purposes.

Effective 7/1/08, the licensure status of every children's foster home in which an IFES recipient is being served will be reported in the QA report for the C&F provider serving these children. The QA process will be modified to ensure that follow up occurs in ensuring that foster homes serving children with DDP-funded supports are licensed.

Specific to FSS Certification: The qualified provider handbook checklist item #27 specifies the requirement that staff who function as Family Support Specialists carry Primary or Comprehensive FSS Certification from DDP/DPHHS, according to requirements in rule, and that all FSSs have access to The Certification Handbook- A Guide for Montana Family Support Specialists. The ongoing certification status of C&F staff is reviewed under checklist item #29 in the comprehensive evaluation process, in which documentation must be provided to verify the certification status of staff. This information is

sampled, but is not summarized on a statewide basis.

Effective 7/1/08, the certification status of every Family Support Specialist providing supports to children in IFES will be verified as part of the DDP annual review. The QA review process will be modified to ensure that follow up occurs in ensuring that Family Support Specialists are certified in accordance with rule and policy.

The qualified provider status of persons providing other waiver services (e.g., respite, transportation, residential habilitation services) is reviewed. In addition, The children's QA process includes a provision (checklist item #39) requiring the agency to have policies, procedures, and practices in place to assure compliance with all applicable federal and State rules, regulations and policies governing the provision of services to children with developmental disabilities.

Failure of a provider to supply evidence of required training and other service requirements (e.g., evidence of background checks) to persons providing waiver reimbursed services is a deficiency in terms of the current Quality Assurance process conducted by the QIS in children's waiver services. This deficiency applies to the review of the qualified provider standards for professional therapy staff as well as non-licensed and non-certified staff, and the subcontracted staff providing services who are reimbursed by the agency contracting with the DDP. These deficiencies would require correction in accordance with the terms of the review process.

The children's services review process will be modified effective 7/1/08 to include a sampling process for verifying that all direct service providers reimbursed for the provision of waiver services meet the qualified provider requirements, as outlined in Appendix C.

Adult Services
The process for achieving qualified provider status as a provider of adult services includes generic application requirements, and documents specific to the provision of particular services. For example, the State licensure requirements for group homes would be sent to the applicant seeking information about becoming a provider of DD group home services. The document is entitled: State of Montana Department of Public Health & Human Services Disability Services Division Developmental Disabilities Program Qualified Provider Standards For the Delivery of Developmental Disabilities Services to Adults with Developmental Disabilities and Their Families. Section V of this document summarizes the requirements a provider would be held accountable for as part of the initial certification process, and later, during the annual review of the service by the QIS. Section V of the Qualified Provider Application Packet requires a review and understanding of the applicable Administrative Rules of Montana, Montana Code Annotated, MT 0208.90 Waiver language, Federal regulations/rules, DDP policies, contract requirements and the QA review policy and the Incident Management Policy. The ARMs and the MCA may be viewed on the web at www.dphhs.state.mt.us in the Legal Section under Programs and Services. Not all the DDP policies and current contract requirements are currently posted on the DDP website, but these would be included in the information packet (hard copy or electronic) sent to a potential applicant. The standards are reviewed within nine months of the applicant achieving qualified provider status and annually thereafter.

Monitoring the training delivered workers providing non-licensed/non-certified providers is addressed in appendices of the quality review process for adult services. Failure of a provider to supply evidence of required training and other service requirements (e.g., evidence of background checks) in the delivery of services to persons served by the waiver is a deficiency in terms of the current quality assurance process conducted by the QIS in children's waiver services. This deficiency applies to the review of the qualified provider standards for professional therapy staff as well non-licensed and non-certified staff, and subcontracted staff providing services reimbursed by the agency contracting with the DDP. These deficiencies would require correction in accordance with the terms of the review process.

The basis for determining compliance with the aforementioned requirements information is the sampling process used when reviewing service providers; not every adult foster home license would be reviewed as part of the annual QA Review. System information verified in accordance with the DDP qualified provider application process, or the quality review process, is not summarized on a statewide basis for trend analysis purposes.

The adult services review process will be modified effective 7/1/08 to include a sampling process for verifying that all direct service providers reimbursed for the provision of waiver services meet the qualified provider requirements, as outlined in Appendix C. In addition, the adult QA process will verify annually that all adult foster care and assisted living providers receiving DDP waiver funded supports are licensed. Effective 7/1/08, the QA process will be modified to ensure the review of the licensure status of every foster home in which the parent is reimbursed for adult foster support.

Monitoring Health and Welfare, and Ensuring Protection from Abuse, Neglect and Exploitation

Children's services

The health, safety and welfare of the child is generally the responsibility of the natural or foster parents. Family Support Specialists and staff from the provider agency visit the recipient in the home setting on an ongoing basis. This limited "traffic flow" is another protection afforded the recipient in ensuring his/her health and safety. The skills of Family Support Specialists in recognizing the signs and symptoms of abuse, neglect and exploitation are critical in this environment. In addition, skills related to the assessment of environmental factors that are statistically linked to the increased likelihood of abuse, neglect and exploitation must be assessed and remediated. The children's QA process does not evaluate the skills of staff in these areas Effective 7/1/08, the children's QA process will review what, if any, training is provided to Family Support Specialists in these areas of abuse prevention. These skills may be in place; the DDP QA process will review the provider efforts to provide this training. One result could be to integrate an abuse prevention training requirement in the Family Support Specialist certification process.

The process for ensuring the health and safety of waiver recipients is outlined in previous sections and copies of the annual review and other procedures (e.g., assessment, planning, training, and the coordination and delivery of needed resources and supports, etc.) are available upon request. QA Reviews are shared with the Executive Director and Board Chairperson of the agency, and the DDP Bureau Chiefs, DDP Regional Manager, and DDP Quality Assurance Specialist. The corporation review date is logged on a statewide QA outcome table, serving to give the Regional Managers and Bureau Chiefs information regarding DDP's performance in adhering to the annual review schedule. The QA review narrative is posted on the DDP website.

The information is not used at this time to compare performance of the corporation from year to year or for trend analysis. Rather, the review serves to identify problems, bring them to the attention of agency and DDP management decision makers for resolution. The timeframe for developing a system for the compilation and reporting of statewide QA trends (based on the QA reviews of children's services and other information) is not set. It is considered premature to project a date for this activity in the absence of a finalized version of the 373 Q requirements. This activity will be scheduled during the renewal of this waiver prior to 7/1/08.

The current Incident Management Policy, effective 11/05, represents a concerted effort by the DDP and others to identify and remediate care-giving deficiencies as they arise. Information gleaned from Incident Reports is summarized in an Access database. Incident management committees focus on areas of risk on a weekly basis, and results are summarized on a monthly basis and these summaries are shared with DDP staff.

DDP's incident management procedures are currently being modified to enable providers to submit incident reports electronically. The system will ensure that reportable incidents are electronically copied to persons who need them, as outlined in the policy. The software program will enable the compilation of trend data based on the needs of the reviewer, including summaries by region, provider and recipient. The integrity of this process is dependent upon the reporting by persons providing direct client services. The electronic reporting of incidents was implemented statewide as of 12/1/07, and work continues on the development of a a statewide database.

Adult Services

The health, safety and welfare of the adult is generally the responsibility of DDP-funded staff providing primary care giving. The Adult Targeted Case Managers visit the recipient in the residential setting on an ongoing basis. This limited "traffic flow" is another protection afforded the recipient in ensuring his/her health and safety. The skills of the case manager in recognizing the signs and symptoms of abuse, neglect and exploitation are critical in this environment. In addition, skills related to the assessment of environmental factors that are statistically linked to the increased likelihood of abuse, neglect and exploitation are needed. The adult QA process currently does not evaluate the skills of staff in these areas. Effective 7/1/08, the DDP will require initial and ongoing ining for all Adult Targeted Case Managers.

The process for ensuring the health and safety of waiver recipients is outlined in previous sections and copies of the annual review and other procedures (e.g., assessment, planning, training, and the coordination and delivery of needed resources and supports, etc.) are available upon request. QA Reviews are shared with the Executive Director and Board Chairperson of the agency, and the DDP Bureau Chief, DDP Regional Mnager, and DDP Quality Assurance Specialist. The corporation review date is logged on a statewide table, serving to give the Regional Managers and Bureau Chief information regarding DDP's performance in adhering to the annual review schedule. The QA review narrative for each corporation is posted on the DDP website. The information is not used to compare performance of the corporation from year to year or for trend analysis. Rather, the review serves to identify problems, bring them to the attention of agency and DDP management and decision makers and to resolve them.

Reviews of agencies occur annually, but information is compiled during the year on an ongoing basis. Information is based on incident reports, planning meeting documents, incident management committee notes, consumer satisfaction surveys conducted by the DDP QIS, customer surveys collected by the agency and reviewed by the QIS and other information as

outlined in the QA Review process. The QA review affords the reviewer an opportunity to gain a composite perspective of the "year in review" based on summarized information.

The current Incident Management Policy, effective 11/05, represents a concerted effort by the DDP and others to identify and remediate care-giving deficiencies as they arise. Information gleaned from Incident Reports is summarized in an Access database. This database is in the process of being fully developed to give the DDP the capacity to project statewide trends. Incident management committees focus on areas of risk on a weekly basis and meeting minutes are summarized in the provider Monthly Trend Report. Copies of these reports are sent to the DDP regional offices.

DDP's incident management procedures are currently being modified to enable providers to submit incident reports electronically. The system will ensure that reportable incidents are electronically copied to persons who need them, as outlined in the policy. The software program will enable the compilation of trend data based on the needs of the reviewer, including summaries by region, provider and recipient. The integrity of this process is dependent upon the reporting by persons providing direct client services. The electronic reporting of incidents was fully implemented statewide by 12/1/07.

Administrative Authority

Appendix A-5 identifies the contracted entities responsible for specific operational and administrative waiver functions. The DDP contracts with agencies providing Adult Targeted Case Management services and Registered Nurses under the Mountain Pacific Quality Health Foundation Contract (also known as the "Foundation"). These contracts outline the service expectations and the terms of reimbursement. The DDP is responsible for developing the administrative rules and policies defining the service and qualified provider standards. The continuation of these contracts on a yearly basis is dependent upon the service providers fulfilling the terms and conditions of the contracts.

Copies of the Foundation contract governing the provision of Registered Nurses in the performance of LOC activities are available upon request. Copies of the contract boilerplate language, and the appendices specific to the provision of children's case management and Adult Targeted Case Management (a Montana State Plan service) are available upon request.

Oversight of the Foundation contract is currently the responsibility of the DDP Waiver Specialist, who reviews and signs off on the monthly invoices and annually renegotiates the contract. Contract oversight of the case management contracts is performed by the DDP Regional Managers, who are responsible for ensuring that services are billed and paid in accordance with the established practices. A small contract is maintained with a private billing agency, enabling State Plan case management services to be entered in the MMIS. The Regional Managers are responsible for renegotiating the case management contracts annually.

Problems are resolved as they arise, often in concert with an agency director, a DDP Regional Manager, a DDP QIS and less frequently, the DDP Bureau Chief and/or Program Director.

Financial Accountability

The requirements associated with audits and financial reviews, required reports and the review of these reports by DDP staff and auditors from the Quality Assurance Division (and sometimes Legislative Fiscal Analysts) are outlined elsewhere in this document. The review of a sample of paid claims histories against the documentation maintained by the provider for services delivered is a part of the QA process used by the DDP QIS to evaluate the delivery of adult services and children's services. As part of reviewing paid claims histories, and effective 7/1/08, the DDP QA process will include the review of the delivery of waiver funded services potentially reimbursable under the State Plan to ensure the waiver is the payer of last resort in all cases.

The QA process is summarized yearly, but the gathering of information, onsite reviews and the desk review of information is stretched out over an extended period of time. Audits are reviewed by DDP Fiscal staff for the purpose of resolving individual issues and/or systemic billing and payment issues, in concert with agency business managers/ accounting staff.

The rates reimbursement project and the the AWACs billing and payment system re-write (designed to provide the flexibility to meet the demands of future billing and data tracking needs for perhaps the next 10 years) involves contracted personnel (Davis/Deshaies and Maximus), DDP and DPHHS program staff, technical and software specialists, programmers and significant numbers of DDP management and line staff and provider staff working together before either of these projects are implemented statewide on 7/1/08.

Roles and Responsibilities

The DDP has a broad base of input in terms of various ongoing projects designed to lead to significant improvements in services to participants. The "Quality Council" includes self-advocates, Disability Rights Montana, parents, providers and DDP staff involved in the Quality Assurance Process. DDP Management is ultimately responsible for ensuring the Quality Assurance Review Process meets the needs of the DDP, consumers and various funding sources and constituencies. Likewise, the implementation of a new adult planning process (Personal Support Planning) involves a contractor (Program Designs) and a myriad of representatives including consumers and families, Disability Rights Montana, providers, DDP staff, case managers and others. The Incident Management System is another recent system improvement effort, involving staff from the ICF-MR, a consultant (Dale Dangremond) and a large contributor base to ensure the needs of DDP, CMS, providers and consumers would be met. The data collection methodology for this project is still a work in progress.

Current efforts to amend this waiver involved a formal request for input to a large number of system stakeholders, including case managers, People First members and MAP represenatives, DD service providers and others. All waiver amendment input was considered, discussed and selectively approved by DDP management and others before this project was initiated. Further effort is needed to systematically enable the gathering of participant, family and service provider input and to develop a conduit for this information to decision makers involved in the waiver amendment process.

DDP will be addressing this issue as part of the current Strategic Planning Across Montana meetings series. Effective 7/1/09, DDP will implement a statewide "open conduit" enabling the free flow of waiver improvement ideas from any and all system participants to the DDP Waiver Specialist. At this time, the DDP is unsure of the best way(s) to accomplish this goal. The DDP Waiver Specialist will compile this information for the review of, and decision-making by, the DDP management team.

DDP does not currently operate with a comprehensive Quality Management System (QMS) driven by the trend analysis of comprehensive system data serving to:
1. Establish priorities and develop strategies for remediation and improvement; and
2. Generate quality management reports based on total system analysis; and
3. Implement, on a scheduled basis, changes in the QMS based on trend reports.

At this time, DDP, the Information Services Bureau and Maximus (redesign contractor) are engaged in updating the AWACS billing and payment system to enable the billing system to capture the required 373 S data, and to incorporate data elements for the rates methodology project, among other things. Currently, DDP generates the required 372 Report fiscal data via Annual Expenditure Report (AER) process. Updating the AWACS database to include all the elements and fields necessary to produce a 373 Q Report based on system data queries was recently discussed with Maximus staff. This requirement is beyond the scope of the DDP's contract with Maximus at this time.

Despite the lack of a formal QMS incorporating the automation of data necessary for the DDP to efficiently implement and maintain systems supporting trend analysis, it should be recognized that the DDP has been moving forward with unprecedented effort in improving various aspects of the DD service delivery system. The current level of activity in system redesign is nothing less than remarkable. Better options, choices, lifestyles and protections/safeguards for recipients have served as the primary catalysts for this change, along with recommendations and input from assigned staff in the CMS regional and central offices.

Effective 7/1/08, DDP staff will be responsible for verifying that Waiver 5 freedom of choice information was fully explained to recipients an/or their persons acting on their behalf during onsite visits to residential sites as part of the DDP QA annual review process. Fully explained is defined as sharing the information contained in the Waiver 5 addendum form with the recipient or person acting on his behalf. This review activity is in addition to the ongoing internal DDP review of waiver files, serving to verify timely completion of the W-5 sign off form by assigned staff.

The DDP Waiver Specialist currently monitors the annual completion of the W-5 form on a sample basis, via the Regional Manager LOC review data submitted electronically on a quarterly basis effective 7/1/07.